

# Exploring Barriers to Maternal and Child Health Care Access in Hoima Referral Hospital Catchment Area in Hoima District, Western Uganda

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## ABSTRACT

Maternal morbidity and mortality remain significant public health and humanitarian concerns. According to the World Health Organization, approximately 6,500 newborns and 810 mothers die each day due to pregnancy- or childbirth-related complications—an unacceptably high number. Most of these deaths are preventable with timely interventions. This study assessed the barriers to maternal and child health care access within the Hoima Referral Hospital catchment area in Hoima District, Western Uganda. A community-based, qualitative cross-sectional study was conducted. Data collection involved structured interviews, after which the principal investigator reviewed completed questionnaires for consistency and completeness. The data was coded, cleaned, and entered into Microsoft Excel before being analyzed using SPSS software version 20. A total of 350 participants were interviewed. The majority (48.0%) were aged 26–35 years, married (77.4%), had attained secondary education (36.6%), and identified as Catholic (35.4%). Several barriers to maternal and child health service uptake were identified, including low-income levels, lack of family support, limited decision-making capacity, inadequate knowledge of pregnancy danger signs, poor road infrastructure to health facilities, lack of privacy at health centers, long distances to health facilities, negative attitudes of healthcare providers, and the gender of the healthcare provider. This study highlights the complex and multidimensional socio-economic and health system challenges that hinder access to maternal and child health services. Socio-economic barriers include low income, limited decision-making capacity, lack of family support, inadequate knowledge of pregnancy danger signs, reliance on traditional birth attendants, and poor road networks. Health system barriers include lack of privacy in health facilities, long distances to healthcare centers, negative attitudes of healthcare providers, and gender preferences in healthcare provision. Addressing these challenges requires a comprehensive approach involving community engagement, improved healthcare infrastructure, and policies that enhance maternal and child health service utilization.

**Keywords:** Maternal morbidity and mortality, Healthcare access barriers, Maternal and child health services, Socio-economic factors, Health system challenges

## INTRODUCTION

Maternal morbidity and mortality remain significant public health and humanitarian concerns [1]. According to the World Health Organization (WHO), approximately 6,500 newborns and 810 mothers die every day due to pregnancy- or childbirth-related complications, an unacceptably high number [2]. Most of these deaths are preventable with timely and appropriate interventions. However, maternal mortality and morbidity rates vary significantly across nations. Low- and lower-middle-income countries account for roughly 94% of all maternal deaths, highlighting stark disparities in access to and utilization of

healthcare services between wealthy and impoverished communities [3]. The use of promotive, preventive, and curative primary healthcare interventions has significantly contributed to the reduction of maternal, neonatal, infant, and under-five mortality rates [4]. In 2015, before the adoption of the Sustainable Development Goals (SDGs), the WHO and its partners published a comprehensive strategy aimed at eradicating preventable maternal mortality (EPMM). This initiative was aligned with SDG target 3.1, which aims to reduce the global maternal mortality ratio (MMR) to fewer than 70 per 100,000 live births by

2030 [5]. The SDG framework has reinforced global efforts to improve maternal, newborn, and child health (MNCH), urging countries to intensify their efforts in reducing maternal and child mortality [6]. While high-income countries have achieved record-low maternal mortality rates, maternal mortality remains a persistent challenge in many low-income nations. In high-income settings, maternal mortality is considered a key indicator of the quality of maternity healthcare, with many of these nations in stage IV or V of the obstetric transition, where non-obstetric causes account for most maternal deaths [7]. However, in the United States, maternal mortality remains higher than in other high-income nations. Data from the Organization for Economic Co-operation and Development and the Centers for Disease Control and Prevention indicate a growing disparity between the U.S. and its peer nations, with maternal mortality rates worsening in recent years [8]. Despite global progress, sub-Saharan Africa (SSA) and South Asia contribute approximately 86% of all maternal deaths worldwide [9]. Over the past 25 years, MNCH indicators have shown an overall upward trend, with many SSA countries experiencing declines in maternal mortality and an increase in the presence of skilled birth attendants [10]. However, SSA still faces significant challenges in reducing maternal deaths. The WHO Atlas estimates that by 2030, SSA will have 390 maternal deaths per 100,000 live births—a figure significantly higher than the 2017 European average of 13 deaths per 100,000 live births and more than five times the SDG target. At the current rate of decline, Africa would need to reduce maternal mortality rates by 86% from 2017 levels to meet the SDG target, a daunting challenge. In Uganda, maternal mortality remains a pressing issue despite gradual progress. According to the Uganda Bureau of Statistics, the maternal mortality rate declined from 438 per 100,000 live births in 2011 to 368 per 100,000 in 2021. This decline is part of a continuous downward trend that began around the year 2000. However, Uganda's maternal mortality

rate remains significantly higher than the global average of 152 deaths per 100,000 live births in 2020 [11]. Additionally, only 65% of childbirths in Uganda are attended by skilled health professionals, a figure that underscores persistent gaps in access to quality maternal care [12]. The primary barriers to maternal and child healthcare utilization in Uganda have been extensively studied. One widely used framework for analyzing maternal mortality is the "Three Delays Model," which identifies three critical delays contributing to maternal deaths: delays in seeking care, delays in reaching a healthcare facility, and delays in receiving appropriate treatment [13]. In rural areas, where healthcare access is particularly limited, these delays have severe consequences for maternal and child health outcomes. Obstacles to accessing maternal and child healthcare services vary but generally include financial constraints, lack of information, reliance on traditional medicine, and poor transportation infrastructure. Additional barriers include inadequate healthcare facility preparedness, socio-cultural beliefs, the absence of emergency transport services, gender preferences for healthcare providers, and negative attitudes of healthcare workers [14]. In child healthcare, major barriers include the financial burden of medical services, limited parental knowledge, the preference for home-based or traditional treatments, and women's lack of time to seek care for their sick children [15]. Understanding and addressing these barriers is essential for improving maternal and child health outcomes. Identifying the primary factors that limit access to healthcare services can help policymakers and program managers design targeted interventions aimed at reducing maternal and newborn mortality. Therefore, this study seeks to examine the barriers to maternal and child healthcare access in the Hoima Referral Hospital catchment area, Hoima District, Western Uganda. This study aimed to determine the barriers to maternal and child healthcare access in the Hoima Referral Hospital catchment area in Hoima District, Western Uganda.

## METHODOLOGY

### Study Design

This was a community based qualitative cross-sectional study.

### Study Area

The study was conducted from Hoima district located in Western Uganda. Hoima district is located in Western Uganda. It is bordered by Buliisa district to the north, Masindi district in the northeast, Kyankwanzi District to the east, Kibaale District to the south Ntoroko District to the south west and Democratic Republic of Congo across Lake Albert to the west. The location of the district headquarters lies approximately 230km northwest of Kampala Uganda's capital city.

### Study Population

The study population was women of reproductive age who had childbirth experiences in last five years attending Hoima Regional Referral Hospital.

### Inclusion criteria

Women who consented to the study.

### Exclusion criteria

Women who declined consent to participate in the study.

Non-residents of Hoima district.

### Sample Size Determination

The researcher used the Kish-Leslie formula to determine the required sample size.

$$n = Z^2 P (1-P) / E^2$$

n=Estimated minimum sample size required  
 $P=65\%$  [12]  
 $Z=1.96$  (For 95% confidence interval)  
 $e$ =Margin of error set at 5%  
 $n=1.96^2 \times 0.65(1-0.65)/0.05^2$   
 $n=350$   
 Therefore, a sample of 350 participants was used.

#### Sampling Procedures

The researcher used purposive sampling technique to recruit participants to the study.

#### Independent variables

Income status  
 Decision maker  
 Family support  
 Knowledge about pregnancy related danger signals  
 Belief in traditional birth attendant  
 Road network  
 Privacy at the health facility  
 Distance to the health centre  
 Attitude of health care providers  
 Sex of health care provider  
 Presence of enough staff at the health facility

#### Dependent variable

Maternal and child health utilization

#### Data Collection Tools

A structured questionnaire was used to interview respondents to gather information relevant to the study objectives. Data was collected from focused

group discussions where a member was chosen to lead.

#### Data Analysis and Management

After collecting the data, the principal investigator checked the completed questionnaires for consistency and completeness. Data was coded, cleaned and entered into the computer using Microsoft Excel. The data was then analyzed using SPSS software version 20.

#### Quality Control

The data collecting tool was pre-tested outside the study area to ensure accuracy and consistency; not altering the meaning of the questions. Data collection tools were checked for completeness and accuracy and stored safely after each field day.

#### Ethical Considerations

A letter from the faculty of clinical medicine and dentistry was handed to the DHO Kiyrandongo district. Research was conducted upon clearance by the DHO. Each respondent was asked for permission before data collection. The respondents were personally questioned to maintain privacy and confidentiality, and the completed questionnaires were retained in a secure location.

#### Limitations of the Study

Self-reported experiences and beliefs may not represent action as some of the responses were provided just for social desirability.

## RESULTS

### Socio-demographic characteristics of study participants

A total of 350 participants were interviewed in the study. Majority (48.0%) of the study participants were

aged 26-35 years, married(77.4%), attained secondary education (36.6%) and 35.4% were catholics as illustrated in table 1 below.

**Table 1: Distribution of socio-demographic characteristics of the study participants**

Variable	Category	Frequency	Percentage (%)
Age(Years)	$\leq 25$	44	12.6
	26-35	168	48.0
	$\geq 36$	138	39.4
Marital status	Married	271	77.4
	Single	39	11.1
	Separated	27	7.7
	Widowed	13	3.7
Level of education	None	71	20.3
	Primary	94	26.9
	Secondary	128	36.6
	Tertiary	57	16.3
Religion	Catholic	124	35.4
	Anglican	87	24.9
	Muslim	65	18.6
	Others	74	21.1

### **Socio-economic barriers**

Six categories that formed economic barriers emerged during data analysis.

#### **Low-income status**

Low-income status was reported by many women as a barrier to maternal health care access. Majority of the women in the study were low-income earners. Despite the fact that maternal health services are free, they said that they still struggle to raise transportation costs. Some women also complained about being told to buy medications outside of the medical facility. Because their husband's income is insufficient to cover their essential expenses, they are unable to afford the expenditures of both transportation and medication.

#### **Lack of decision-making capacity**

Women are denied the ability to choose whether they require maternal and child health services. Women's access to maternity and child health services is decided by their husbands. Women must consult with their spouses and other family members before choosing to visit a health institution because they are not financially independent and rely on them for financial support. Participants also reported that sometimes, husbands declare there is no need to take their women to the hospital and refuse to let them give birth there.

#### **Lack of family support**

Lack of family support was also reported as a barrier to maternal and child health utilization. Women shoulder a lot of the burden of caring for their families and homes. They are unable to leave their homes and receive no support from their husbands or other family members. Participants stated that their spouses work hard and are constantly busy. They are never present. Participants further reported that some families still stick to traditional norms and encourage women to seek care from traditional birth attendants. Participants reported that some families ask "Why do you have to give birth at the medical facilities when our mothers, grandmothers, and great grandmothers never gave birth there and experienced no problems? They were all helped by traditional birth attendants".

#### **Lack of knowledge about pregnancy danger signs**

Lack of knowledge about pregnancy related danger signs was another issue cited by participants. Though majority of the study participants were educated to some level, they didn't have understanding of

pregnancy related danger signs. They are unaware about the advantages of visiting and giving birth at medical facilities as well as the risks of giving birth at home. Some of them opt to give birth at home, which increases the risk of mortality from heavy bleeding, because of misconceptions about blood transfusions.

#### **Trust in traditional birth attendants**

This was another barrier to maternal and child health utilization. Easy access and affordability of TBAs make mothers prefer them to health care units.

#### **Poor road network to health facilities**

Further, poor road network was reported as another barrier to maternal and child health service utilization. This increases the perceived distance to health facilities coupled with long travel time to reach which discourages women.

#### **Health system barriers to access of maternal and child health services**

##### **Distance to the health facility**

One more barrier to getting services for maternal health care, according to study participants, is distance. Mothers expressed their dissatisfaction with the distances involved and the lack of dependable transportation options that would enable them to get to the medical institution.

##### **Lack of privacy at the health facility**

Another problem that mothers lamented was the lack of privacy at the medical facilities. It might be challenging for a patient to describe her concern to a healthcare professional when there are other patients or healthcare professionals in the room. Due to inadequate infrastructure, more than one patient may be attended to at the same time in the room. Additionally, there is more than one medical professional in the consultation room. This makes it difficult for them to air out their issues with confidence.

##### **Attitude of health care providers**

Bad attitude of health care providers was also listed among the barriers to utilization of maternal and child health services among the study participants. Mothers reported that midwives are harsh to them and do not feel like having the same encounter again.

##### **Gender of health provider**

Additionally, respondents reported gender of health care provider as another barrier to uptake of maternal and child health services. They reported that they are not comfortable being attended to by male health workers.

## **DISCUSSION**

Utilization of maternal and child healthcare services is a crucial metric for assessing the health of mothers and children [13]. Obstacles to accessing health care have a wide range of effects on maternal and child health and survival, especially in rural areas where access to or use of health services is limited. This study assessed barriers to utilization of maternal and child health services.

### **Socio-economic barriers to uptake of maternal and child health services**

The use of healthcare services during pregnancy, labor, and the postpartum period is crucial for maternal and child survival and health. Despite the fact that these services are free, the majority of women do not use them. Participants in the study have highlighted a number of obstacles to using

maternal and child health services. In the present study, utilization of maternal and child health services was hindered by low-income status, lack of decision making capacity, lack of family support, lack of knowledge about pregnancy danger signs, trust in traditional birth attendants and poor road network to health facilities. Similar to a study in Somalia, low-income status was identified as a barrier to utilization of maternal and child health services by study participants in this survey [16]. Participants in this survey claimed that most mothers do not attend prenatal, delivery, and postnatal care services because they do not have enough money for transportation and medicine. The finding of this study is also consistent with research done in Uganda [17]. Poverty was further cited as a barrier to maternal and child health service utilization according to a study in Kenya [6]. This study further revealed that lack of decision-making capacity by women was reported as a hindrance to utilization of maternal and child health services. This is in agreement with a study done in Somalia [16]. This study indicated that lack of knowledge was a barrier to maternal and child health service utilization which is concordant with the findings of a study in Kenya [6]. Trust in traditional birth attendants was a barrier to utilization of maternal and child health services which is similar to a study in Ethiopia [14].

#### **Health system barriers to utilization of maternal and child health services**

Mothers also identified health system barriers to utilization of maternal and child services. These barriers include; distance to the health facility, lack of privacy at the health facility, attitude of health care providers and gender of health care provider. This study found that gender of health care provider was

This study identified complex and multidimensional socio-economic and health system hurdles that limit the uptake of maternal and child health services. The socio-economic factors that impede utilization of maternal and child health services include; low-income status, lack of decision-making capacity, lack of family support, lack of knowledge about pregnancy danger signs, trust in traditional birth attendants and poor road network to health facilities. The health system barriers to maternal and child service utilization identified in this study were; lack of privacy in the health facilities, distance to the health center, attitudes of health care providers and gender of health provider.

#### **Recommendation**

Government and its partners should promote women's empowerment and girls' education in order to raise the socioeconomic status of mothers. This will enable mothers to play a more active role in deciding when and where to seek out maternal and child health services. Additionally, it would make it

also a barrier to utilization of maternal and child health services. This is consistent with a finding of a study in Kenya which noted that according to the opinions of the participants, a significant obstacle to utilizing MNCH services in their community was the service provider's gender [6]. Participants in the survey remarked that women in their community favored female healthcare workers due to cultural views, while some also mentioned religious commitments. Men and women continue to express their displeasure of male service providers attending to expectant women. Men appear to think that women don't like having male attendants because of cultural and religious expectations. Distance to the health facility was noted to be a barrier to access of maternal and child health services. Similar finding was revealed by a study in Kenya [6] which indicted that both during the pre- and post-intervention evaluations, a shortage of transportation was identified as a major problem. Particularly in emergency situations where mothers needed prompt treatment, this proved difficult. Due to their unfortunate lack of access to ambulance services, they choose to give birth at home or in neighborhood low-quality medical facilities. Women may experience unforeseen problems during labor that may call for more advanced facilities including a surgical theater [18]. Because there aren't many alternative options, most mothers have to use public means or walk to the hospital. Third trimester pregnant women find this to be very challenging. Difficulties in reaching the health care facility was also noted to hinder access to maternal health care services by a study in Uganda [19].

#### **CONCLUSION**

more likely for mothers to reject harmful traditional beliefs and practices, which would have a cascading effect on pregnant women's ability to receive and afford maternal care. Maternal and child health services should be planned and provided in a way that is medically appropriate, maintains privacy and confidentiality, and is sensitive to the culture, needs, and preferences of expectant mothers in order for mothers to have a positive experience at the health facility. The number of female employees at health facilities should be increased, and after that, they should receive communication skills training so they can build rapport with the mothers attending the services. Government and its partners should spend money on improving the functionality of ambulance services, establishing appropriate referral mechanisms, addressing costs associated with it, and, most importantly, taking into consideration offering return transportation services.

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